MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION				
Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No			
Requestor's Name and Address Texas Imaging & Diagnostic Center	MDR Tracking No.: M4-03-8196-01			
3840 W. NW. Highway, Suite 400	TWCC No.:			
Dallas, Texas 75220	Injured Employee's Name:			
Respondent's Name and Address Liberty Mutual Fire Insurance Company	Date of Injury:			
Box 28	Employer's Name:			
	Insurance Carrier's No.: 949454323			

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due	
From	То	Ci i Code(s) of Description	Amount in Dispute	Amount Duc	
07/26/02 07/26/02		99070-ST	\$187.11	\$187.11	

PART III: REQUESTOR'S POSITION SUMMARY

"We were not properly reimbursed for the Sterile Supplies CPT code (99070-ST). The Cervical Myelogram with Post Myelogram CT Scan falls under Surgical Procedures Performed in a Doctor's Office. We meet all the requirements listed under this guideline in order to bill and be paid for this code."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier states "...after much research, has determined that \$100.00 is a fair and reasonable reimbursement for a sterile tray used for epidural steroid injections. Other providers within the same geographical area routinely accept \$100.00 as a fair and reasonable reimbursement for their sterile trays used for epidural steroid injections." EOBs state, "The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The provider submitted product information and redacted EOBs from various insurance carriers indicating what they had paid. The information provided indicates that the carriers had reimbursed the full amount the provider billed. The provider had the more compelling evidence that indicates a fair and reasonable rate of reimbursement than the carrier provided per rule 133.307(g)(3)(D). No other denials were noted in the claim file. Therefore, based on the information provided additional reimbursement is recommended.

PART VI: DET	AIL FINDINGS (I	f needed)					
					1		
					Total l	Left Column:	\$0.00
					Total A	Amount Due:	\$187.11
PART VII: CO	MMISSION DECI	SION AND ORDE	ER				
		rued interest due		. The Division ayment to the re	equestor within 2		
Author	rized Signature		Турес	d Name	Date of Order		
PART VIII: VO	OUR RIGHT TO R	REQUEST A HEAD	RING				
Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute. Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.							
PART IX: INSU	JRANCE CARRIE	ER DELIVERY CI	ERTIFICATION				
I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.							
i nereby verify	unai i received	a copy of this L	occision and Ord	ici iii iiie Ausiln	Representative	S UUX.	
Signature of I	Signature of Insurance Carrier: Date:						